

Addiction Medicine Fellowship Application Instructions

1. Complete the application form.
2. Send the following documentation with the application: Updated Curriculum Vitae. Describe any gaps of more than one month in education or training, if applicable.
3. Personal Statement describing your interest in Addiction Medicine and plans for future professional work.
4. Attestations page with your signature.
5. Request a minimum of three letters of reference from faculty members. Letters must be sent directly to the Program Coordinator or Program Director.
6. A copy of your Medical School Transcript and Dean's Letter must be sent directly to Program Coordinator.
7. Mail (or send electronically, if appropriate) the completed application package to include the Application, Personal Statement, and your CV.

8. Contact information:

Lynda Kirk, Fellowship Coordinator
352-294-4904
lynda.kirk@ufl.edu

UF Health Florida Recovery
Center / Admin Building
3939 SW 13th Street
Gainesville, FL 32608

William Greene, MD, Program Director
352-294-4904

Addiction Medicine Fellowship Application Form

Date of Application: _____ Anticipated Start Date for Addiction Medicine training: _____

Full Name: _____
Last First Middle

Current PG Yr: _____ PG- level on start date: _____

Present Mailing Address:

Permanent Mailing Address:

Telephone: Home: _____ Office: _____ Cell: _____

Email Address: _____

Place of Birth: _____ DOB: _____

Legally eligible to work in USA? _____ Visa Status _____
(Foreign Nationals Only)

MDs: List USMLE dates and scores below:

USMLE Step I _____ USMLE Step II _____
(Date) (Score) (Date) (Score)

USMLE Step III _____
(Date) (Score)

DOs: List COMLEX Dates and Scores below:

Level 1 _____ Level 2 _____ Level 3 _____
(Date) (Score) (Date) (Score) (Date) (Score)

ECFMG Number and Date _____

Board Certification: If Board Certified, list name of Board and Year of Certification below:

LICENSURE:

State _____ Number _____ Date _____ Type _____ Expiration Date _____

Educational Data

Undergraduate Education: Please provide full name and mailing address for all schools listed.

Start and End Dates: _____ to _____ List Degree awarded: _____

Institution Name Street Address

City and State

Start and End Dates: _____ to _____ List Degree awarded: _____

Institution Name Street Address

City and State

Graduate Education - (Medical and Masters or Doctoral Program)

Start and End Dates: _____ to _____ List Degree awarded: _____

Institution Name Street Address

City and State

Start and End Dates: _____ to _____ List Degree awarded: _____

Institution Name Street Address

City and State

Postgraduate Medical Education:

INTERNSHIP: (if more than one, please provide additional information on a separate sheet)

Start _____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or No

Institution Name Street Address

LIST SPECIALTY City and State

RESIDENCY: (if more than one, please provide additional information on a separate sheet)

Start _____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or No

Institution Name Street Address

LIST SPECIALTY City and State

FELLOWSHIP: (if more than one, please provide additional information on a separate sheet)

Start _____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or No

Institution Name Street Address

LIST SPECIALTY City and State

OTHER Professional training:

Start _____ to _____
(Month/Day/Year) (Month/Day/Year)

ACGME Accredited: _____
Yes or No

Institution Name

Street Address

LIST SPECIALTY

City and State

Please check this box if you are attaching additional pages

Personal Statement

Describe your interest in Addiction Medicine and explain your plans for future professional work.

Name: _____

Attestations

Circle Yes or No in response to each question below. If you answer "Yes" to any of the questions, please attach a written explanation on a separate page for each question.

Malpractice

Have you received any settlements, malpractice claims, and/or lawsuits, pending or closed during the previous 10 years? Yes or No

Miscellaneous

1. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation? If yes please attach a detailed written explanation. Yes or No
2. Have you ever been denied a professional license in any state? Yes or No
3. Have you ever been requested to appear before any professional society? or licensing board because of a complaint or charge? Yes or No
4. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? Yes or No
5. Have your hospital staff privileges ever been denied, suspended, revoked, placed on probation, voluntarily surrendered or in any other way restricted, or have they been or are they currently under investigation? If "Yes," please attach a detailed written explanation..... Yes or No

Applicant's affidavit:

I certify that all the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment.

Signature of Applicant: _____ Date: _____